I would suggest that women with cytological evidence of HSV infection be advised of their diagnosis and urged to inform their obstetrician of the same. It is possible that ulceration has gone unnoticed in the past and an opportunity to corroborate the cytological diagnosis by viral culture may present itself to the vigilant medical attendant. Alternatively, infection may be truly confined to the cervix, in which case the obstetrician will have no external clinical indicator of recurrence. Virological screening in the latter stages of pregnancy may have a particular place in the management of this selected group of patients, although its routine use in all those with a history of genital herpes is disputed.[4] At the very least, these women should be advised to attend early in labour so that a full genital examination, including speculum examination of the cervix might be performed.

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1 Radcliffe KW, Mindel A. Genital herpes diagnosed by cervical cytology. *Genitourin Med* 1988;**65**:284.
2 Brown ST, Jaffe HW, Zaidi A, *et al.* Sensitivity and specificity of diagnostic tests for genital infection with herpes virus hominis. *Sex Trans Dis* 1979;**6**:10–13.
3 Nahmias AJ, Naib ZM, Josey WE, Clepper AC. Genital herpes simplex infection: virologic and cytologic studies. *Obstet Gynecol* 1967;**29**: 395–400.
4 Kelly J. Genital herpes during pregnancy. *Br Med J* 1988;**297**:1146–7.

Dr Radcliffe and Dr Mindel reply:
We agree with Dr Stack that women with herpes detected by cytology alone should be offered the opportunity of careful monitoring during subsequent pregnancies.

Labial adhesions after genital herpes infection – authors reply

Haran and colleagues[1] appear to have missed the point of our case report[2] on labial adhesions after genital herpes infection, since it was not so much the occurrence of the adhesions per se but rather their persistence and related consequences which were important. We have little doubt that the majority of physicians, like ourselves, who see patients with florid primary herpes have seen varying degrees of adhesion formation. These adhesions generally require little more than gentle digital separation and other simple measures because of their flimsy nature.

Our case report served to show how relatively quickly, since it was less than three weeks from the onset of her attack to our first seeing her, the adhesions had become so fixed, rendering simple digital separation impossible. The consequence of this was that the patient was to have a general anaesthetic and laser separation, and although this was in our case not ultimately required, as the majority of the adhesions had resolved spontaneously, in a similar case report[3] the patient was not so fortunate.

To our knowledge this persistence in adhesions is relatively rare, the rarity undoubtedly being attributed to the diligent management by physicians of the primary stages of the infection. Our case report hopefully served to highlight that such diligence is necessary in order to avoid long-term complications leading to unnecessary surgical procedures under general anaesthesia.

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1 Haran MV, Crawshaw S, Natin D. Labial adhesions after genital herpes infection (Letter). *Genitourin Med* 1989;**65**:349.
2 Walzman M, Wade AAH. Labial adhesions after genital herpes infection. *Genitourin Med* 1989;**65**:187–8.
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(Ed: This correspondence is now closed.)

Yersinia pseudotuberculosis infection as a cause of reactive arthritis as seen in a genitourinary clinic: case report

The recent case report of reactive arthritis associated with Yersinia pseudotuberculosis infection[1] highlights a growing problem. Statistical returns from genitourinary medicine (GUM) clinics in England indicate that the number of cases of non-specific genital infection NSGI with arthritis has been increasing steadily since 1984 although the total number of cases of NSGI dropped in 1987.[2] Because of the nature of reactive arthritis, it is likely that many cases will be referred to a GUM clinic, with, or without evidence of urethritis, rather than attend spontaneously.

It is important that genitourinary physicians are aware of the full differential diagnosis and are familiar with the tests which are required to elucidate the underlying cause of the condition.

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1 Lindley RI, Pattman RS, Snow MH. Yersinia pseudotuberculosis infection as a cause of reactive arthritis as seen in a genito-urinary clinic; case report. *Genitourin Med* 1989;**65**:255–6.
2 Department of Health Statistics and research division. New cases seen at genitourinary medicine clinics 1987. Summary information from form SBH 60: 1987.

Holey prepuce following genital ulceration

I read with interest the letter from Drs Maiti and Haye[1] describing a patient with a circular hole in the foreskin following treatment with podophyllin. A similar case but with a larger hole seen recently in a patient who had not received podophyllin is described.

A 27 year old Zulu man attending the STD clinic at King Edward VIII hospital, Durban with a urethral discharge was found to have a large defect in the dorsal aspect of the foreskin through which the glans penis protruded (fig). On further questioning the patient described an episode of sub-preputial genital ulceration 6 months previously involving the coronal sulcus which had penetrated through the foreskin. Antibiotics were prescribed by a local doctor and healing had occurred slowly. He did not appear concerned about the resultant